



Launch of the *Being Human: Framework for Safety Culture within Health and Social Care in Northern Ireland*

Wednesday 17 September 2025

## **Overview and next steps**

# Acknowledgements

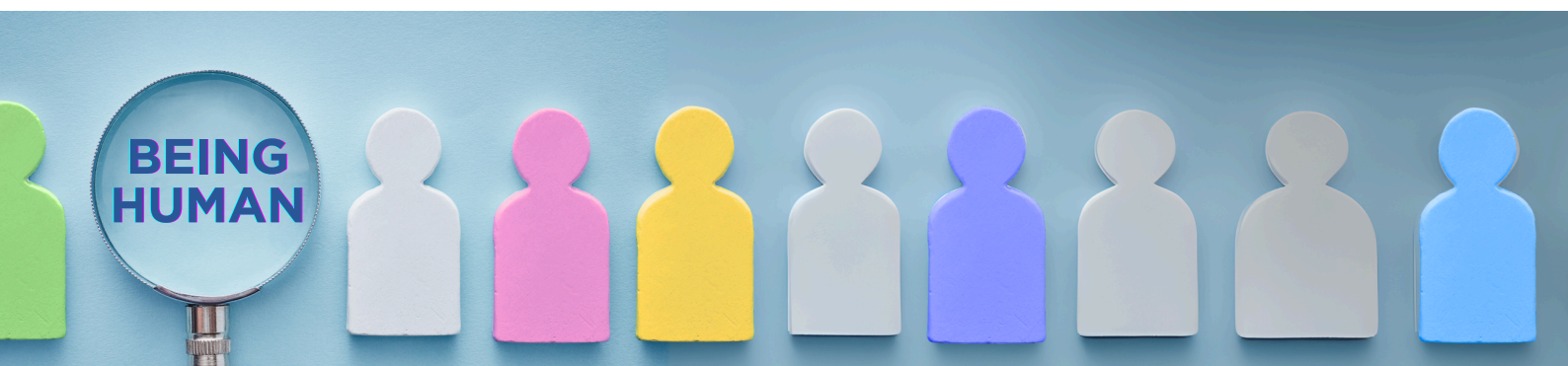
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RQIA would like to thank all of those involved in this work, including co-production partners, people with Lived Experience, external experts, and key stakeholder organisations, for contributing their time and providing knowledge and expertise to support the development of ***Being Human: A Framework for Safety Culture within Health and Social Care in Northern Ireland***.

This includes representatives from:

- Department of Health
- General Medical Council
- Health and Social Care Organisations
- Northern Ireland Medical and Dental Training Agency
- Northern Ireland Practice and Education Council for Nursing and Midwifery
- Northern Ireland Public Services Ombudsman
- Northern Ireland Social Care Council
- Nursing and Midwifery Council
- Patient Client Council
- People with Lived Experience
- Public Health Agency
- Regulation and Quality Improvement Authority (including Health and Social Care Quality Improvement)
- Royal College of General Practitioners
- Royal College of Midwives
- Royal College of Nursing
- Royal College of Psychiatrists
- Royal College of Surgeons
- Trade Unions
- Ulster University
- Voluntary Sector Organisations

We very much appreciate their dedication and commitment to improving safety culture within Health and Social Care to ensure that it is one which is safe and compassionate; just and open; and, continually learning and improving.



# Introduction

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The core purpose of the Regulation and Quality Improvement Authority, as the system regulator for Health and Social Care (HSC) in Northern Ireland, is to secure and improve the safety and quality of health and social care services.

In November 2022, RQIA made a number of legacy commitments in relation to the improvement and assurance of safety culture within HSC [1].

These commitments were made following the stark learning arising from the RQIA Expert Review of Records of Deceased Patients of Michael Watt, which raised significant concerns about how patients, families and HSC staff experience culture within the Northern Ireland Health and Social Care System.

RQIA had the privilege of meeting with families, many of whom shared testimony of not being listened to, and not being treated with empathy, compassion or respect, and of healthcare professionals seeming disempowered to raise concerns.

These concerns echo the findings of numerous inquiries and reviews within HSC, and the NHS more widely, undertaken in recent decades; which highlight a need for a concerted effort to improve safety culture within our Health and Social Care service.

Following significant scoping work and engagement with stakeholders across the region through a series of roundtable discussions, it was determined that, in order to fulfil RQIA's legacy commitment, there was a requirement for an overarching framework to set out clear expectations for how safety culture may be strengthened and assessed within HSC.

In December 2024, RQIA secured a mandate from system partners and representatives with lived experience to take this work forward by co-production.

Co-production work commenced in April 2025, and completed in July 2025, via three co-production work streams:

- Safe and Compassionate;
- Just and Open;
- Learning and Improvement.

[1] Legacy Commitment 7: Strengthen the assessment of a safety culture, particularly around evidence of listening to patients and families, and evidence that staff feel safe to challenge each other and raise concerns. Legacy Commitment 8: Require improvements if there is evidence of substandard systems, or poor culture or care. Legacy Commitment 9: Use its position as independent regulator to support the adoption of openness and candour across all services, especially when reporting that care has gone wrong.

# The Purpose of the Framework

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Underpinned by the core values, principles and standards for Health and Social Care, including DoH Quality Standards, 2006, the purpose of the Framework is:

1. To set out expectations of what a good safety culture looks like for the HSC system, patients and the public;
2. To provide the foundation for assessing safety culture within HSC organisations.[1]

The Framework, the process of developing it, and any accompanying tools and guidance, are intended to achieve an overall aim of fostering a culture within the HSC system that is safe and compassionate; just and open; and, continually learning and improving.

## Scope of the Framework

The Framework is intended for use within the HSC system, including HSC Trusts, regional Arms Length Bodies and other HSC organisations (e.g. the Public Health Agency and others). Whilst its principles can be applied to other settings, such as primary care, the independent sector, and health and social care settings in other jurisdictions, the Framework has been developed with the specific intention of assuring and improving safety culture within the six Health and Social Care Trusts in Northern Ireland.

## The Framework is designed to:

- Set out ‘what good looks like’ in relation to safety culture within HSC organisations. It will inform the development of assessment tools and guidance that can be used for self-assessment by HSC Trust Boards, and will be of value to newly-established Patient Safety and Quality Committees and other HSC bodies.
- Set out clear expectations for the HSC system, that are underpinned by core values, principles and standards for Health and Social Care, including DoH Quality Standards, 2006.
- Define a culture within HSC that is safe and compassionate; just and open; and, continually learning and improving.
- Support HSC Trust Boards and boards of all other HSC bodies, as well as senior leaders, to foster a safe and compassionate; just and open; and, continually learning and improving culture within HSC services through: consistent, compassionate leadership; scaling up and spreading good practice; and promptly identifying and addressing poor practice.

[1] Assessment methodology and tools to be developed as part of Phase 2

- Enable and empower HSC staff, patients and families to articulate the safe and compassionate environments they deserve to encounter, whilst empowering them to constructively challenge when standards fall short of what is required to ensure staff and patient safety.
- Be meaningful and relevant to all those who use it, by setting out how its principles may be practically applied in real-life situations.
- Ensure the Framework will be used by RQIA as part of its function to inform the DoH of the quality and safety of HSC services.[1]

## Overview of the Framework

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*Being Human: A Framework for Safety Culture within Health and Social Care* sets out what a good safety culture looks like within HSC in Northern Ireland. It defines safety culture as one that is safe and compassionate; just and open; and, continually learning and improving. It delineates a shift away from process-centred, ‘tick box’ approaches to Health and Social Care, and, instead focuses on embedding a relational, person-centred ethos at all levels of the HSC system; understanding that the relationships we have with ourselves and with each other, as patients, family members and colleagues, are HSC’s greatest asset to ensuring a safe, high-quality HSC system.

Underpinned by HSC Values, and aligned to best-practice standards, including DoH Quality Standards, 2006, the Framework defines three overarching domains that represent the collective mindset necessary to drive a strong safety culture.

- **Domain 1: Commitment to Patient Safety and Staff Wellbeing**
- **Domain 2: Compassion, Civility and Respect**
- **Domain 3: Curiosity and Constructive Challenge**

Each of these domains encompass a number of expectations for HSC organisations, underpinned by a series of indicators, setting out the enabling system factors, behaviours and outcomes that provide evidence of a good safety culture.

Accompanied by case studies, good practice examples, along with examples of poor behaviour, they are designed to be enabling and empowering for HSC staff, patients and families.

[1]Under the 2003 Order, the Regulation and Quality Improvement Authority has statutory functions to conduct reviews, inspections and investigations of, and make reports on, arrangements by HSC Trusts for the purposes of monitoring and improving the quality of the HSC services.

# Being Human: A Framework for Safety Culture within Health and Social Care

| Domains  | Themes   | Expectations   |
|--|--|--|
| Commitment to Patient Safety and Staff Wellbeing | Fostering collective accountability for Patient Safety | There is shared understanding of collective accountability at all levels, acknowledging that ultimate accountability for patient safety sits with HSC Trust boards |
|  |  | There is a 'Floor to Board' commitment to patient safety   |
|  |  | Clinical care is consistently safe, effective and underpinned by evidence-based practice   |
|  |  | Tackling health inequalities is a key safety priority  |
|  | Looking after staff wellbeing                          | Staff are nurtured, supported and enabled to fulfil their potential  |
|  |  | Diversity is welcomed, championed and supported, understanding that it makes teams more effective  |
|  | Listening to patients, families and staff              | Voices of staff, patients and families are embraced as an important barometer of safety  |
| Compassion, Civility and Respect                 | Leading with compassion                                | Compassionate leadership is fundamental to all other aspects of a safety culture   |
|  | Empowering staff, patients and families                | Effective teamwork and psychological safety is nurtured within teams   |
|  |  | Staff at all levels are kind and civil and work within safe and compassionate teams  |
|  |  | Patients and families are empowered, enabled and informed  |
|  | Enhancing openness, trust and mutual respect           | Staff at all levels listen, hear and act on concerns of patients, families and colleagues  |
|  |  | All impacted by patient safety incidents experience fair, compassionate and restorative responses and actions  |
|  |  | Openness and candour is promoted and supported at all levels in the organisation   |
| Curiosity and Constructive Challenge             | Addressing fear and defensiveness                      | Fear is addressed by acknowledging the impact of past trauma and by challenging unhelpful narratives and beliefs   |
|  |  | Early engagement is embraced as an opportunity for early resolution and system learning  |
|  | Making it safe for staff to speak up                   | Staff at all levels are empowered to provide and receive constructive feedback as a means to learning and improving the HSC system                                 |
|  |  | Speaking up is highly valued and encouraged and results in action to improve patient safety  |
|  | Being curious to learn and improve                     | Time and space for reflection is created at all levels in the organisation   |
|  |  | Learning is shared in a meaningful way that has impact   |

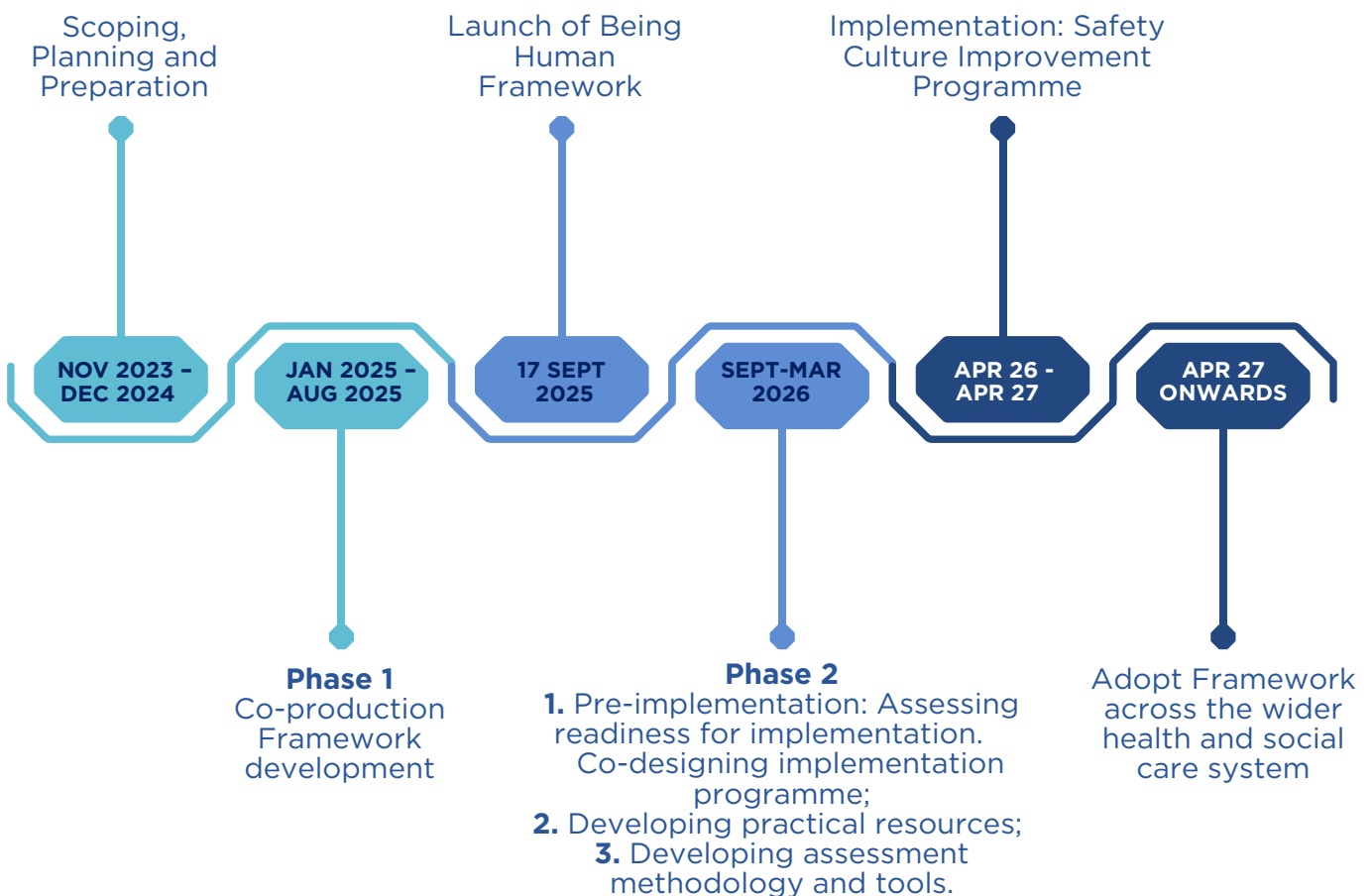
# Next Steps

The Framework is of particular benefit to HSC Trust boards, and newly-established Patient Safety and Quality Committees, and to all HSC bodies considering organisational culture, as they determine how best to improve and assure safety for staff, patients and the public.

It is not a one-off and standalone piece of work, but rather the continuation of a journey. In the short to medium term, further work is required to develop the tools, guidance and any adjuncts necessary to facilitate Framework testing, implementation and evaluation. In the longer term, it will require whole-system adoption to maximise safety culture within all aspects of Health and Social Care.

In the meantime, the Framework should be assimilated, reflected upon and utilised to shift mindsets, influence behaviour and define the actions required to embed a safe and compassionate; just and open; and, continually learning and improving culture within HSC.

## Project milestones



## References

1. Developing a Just, Open and Learning Culture in HSC. Summary of RQIA Hosted Roundtable, May 2024. Available at: [6454dddc-5c14-4189-bb14-318000817988.pdf](#) Cited August 2025
2. Speak Up. Why Regulation in an Open Health and Social Care System is important. RQIA Roundtable. November 2023. Available at [200886ea-e603-484e-97d3-b8098a3f323c.pdf](#) Cited August 2025



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